

		FOR OHF USE					

LL 1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041897</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>CARE CENTRE OF URBANA</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>907 N. LINCOLN AVE.</u> <u>URBANA</u> <u>61801</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>CHAMPAIGN</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(847)674-4700</u> Fax # <u>(847)674-4733</u>		(Type or Print Name) <u>BRADLEY ALTER</u>	
IDPA ID Number: <u>36-4082501</u>		(Title) <u>SECRETARY</u>	
Date of Initial License for Current Owners: <u>6/01/96</u>		(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	
Type of Ownership:		Paid Preparer (Print Name and Title) <u>BOB KAGDA PARTNER</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD.</u> <u>3750 W. DEVON AVE., LINCOLNWOOD, IL 60714</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847)675-3585</u>			

Facility Name & ID Number CARE CENTRE OF URBANA# 0041897 Report Period Beginning: 01/01/2001 Ending: 12/31/2001**III. STATISTICAL DATA**A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,135</u>	<u>2,135</u>	8
9	SNF/PED					9
10	ICF	<u>20,754</u>	<u>1,917</u>	<u>41</u>	<u>22,712</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,754</u>	<u>1,917</u>	<u>2,176</u>	<u>24,847</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 68.76%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/01/96

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 06/01/96 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 12 and days of care provided 2,135Medicare Intermediary ADMINASTAR FEDERAL**IV. ACCOUNTING BASIS**MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

CARE CENTRE OF URBANA

0041897

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	131,654	6,092	5,245	142,991		142,991		142,991		1
2	Food Purchase		97,351		97,351		97,351	(4,682)	92,669		2
3	Housekeeping	85,574	17,332		102,906		102,906	267	103,173		3
4	Laundry	30,438	12,382		42,820		42,820		42,820		4
5	Heat and Other Utilities			69,224	69,224		69,224	430	69,654		5
6	Maintenance	13,946	15,748	7,080	36,774		36,774	1,308	38,082		6
7	Other (specify):* SCAVENGER			3,881	3,881		3,881		3,881		7
8	TOTAL General Services	261,612	148,905	85,430	495,947		495,947	(2,677)	493,270		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	699,111	86,199	94,723	880,033		880,033	11,428	891,461		10
10a	Therapy			4,545	4,545		4,545		4,545		10a
11	Activities	33,536		2,164	35,700		35,700		35,700		11
12	Social Services	32,592		1,944	34,536		34,536		34,536		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	765,239	86,199	112,376	963,814		963,814	11,428	975,242		16
	C. General Administration										
17	Administrative	45,496		23,000	68,496		68,496	6,869	75,365		17
18	Directors Fees										18
19	Professional Services			51,583	51,583		51,583	6,419	58,002		19
20	Dues, Fees, Subscriptions & Promotions			16,272	16,272		16,272	(4,428)	11,844		20
21	Clerical & General Office Expenses	72,981	14,807	114,575	202,363		202,363	(21,679)	180,684		21
22	Employee Benefits & Payroll Taxes			188,034	188,034		188,034	16,171	204,205		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,677	2,677		2,677	5,812	8,489		24
25	Other Admin. Staff Transportation			1,913	1,913		1,913	6,700	8,613		25
26	Insurance-Prop.Liab.Malpractice			46,449	46,449		46,449	2,980	49,429		26
27	Other (specify):*										27
28	TOTAL General Administration	118,477	14,807	444,503	577,787		577,787	18,844	596,631		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,145,328	249,911	642,309	2,037,548		2,037,548	27,595	2,065,143		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number

CARE CENTRE OF URBANA

#0041897

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			22,185	22,185		22,185	(3,144)	19,041			30
31	Amortization of Pre-Op. & Org.			579	579		579		579			31
32	Interest			145,180	145,180		145,180	(1,515)	143,665			32
33	Real Estate Taxes			44,061	44,061		44,061		44,061			33
34	Rent-Facility & Grounds			372,389	372,389		372,389	3,670	376,059			34
35	Rent-Equipment & Vehicles			2,915	2,915		2,915		2,915			35
36	Other (specify):*											36
37	TOTAL Ownership			587,309	587,309		587,309	(989)	586,320			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			58,043	58,043		58,043	(20,102)	37,941			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			112,246	112,246		112,246	(20,102)	92,144			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,145,328	249,911	1,341,864	2,737,103		2,737,103	6,504	2,743,607			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number CARE CENTRE OF URBANA

0041897

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,057)	30		9
10	Interest and Other Investment Income	(1,564)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,468)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(214)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,056)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(647)	20		28
29	Other-Attach Schedule	867	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (15,139)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	21,643	SCHED	34
35	Other- Attach Schedule		ATTACHED	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 21,643		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 6,504		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
CARE CENTRE OF URBANA

Page 5A

ID# 0041897
Report Period Beginning: 01/01/2001
Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEF MAINTENANCE	\$ 867	6
2			
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48			
49	Total	867	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARE CENTRE OF URBANA

0041897

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,682)	0	0	0	0	0	0	0	0	0	0	(4,682)	2
3	Housekeeping	0	0	267	0	0	0	0	0	0	0	0	267	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	430	0	0	0	0	0	0	0	0	430	5
6	Maintenance	867	0	441	0	0	0	0	0	0	0	0	1,308	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,815)	0	1,138	0	0	0	0	0	0	0	0	(2,677)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	11,428	0	0	0	0	0	0	0	0	11,428	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	11,428	0	0	0	0	0	0	0	0	11,428	16
	C. General Administration													
17	Administrative	0	(23,000)	29,869	0	0	0	0	0	0	0	0	6,869	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	6,259	160	0	0	0	0	0	0	0	6,419	19
20	Fees, Subscriptions & Promotions	(4,703)	0	275	0	0	0	0	0	0	0	0	(4,428)	20
21	Clerical & General Office Expenses	0	(87,120)	64,121	1,320	0	0	0	0	0	0	0	(21,679)	21
22	Employee Benefits & Payroll Taxes	0	0	12,597	3,574	0	0	0	0	0	0	0	16,171	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,257	555	0	0	0	0	0	0	0	5,812	24
25	Other Admin. Staff Transportation	0	0	5,391	1,309	0	0	0	0	0	0	0	6,700	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,980	0	0	0	0	0	0	0	0	2,980	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(4,703)	(110,120)	126,749	6,918	0	0	0	0	0	0	0	18,844	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,518)	(110,120)	139,315	6,918	0	0	0	0	0	0	0	27,595	29

Summary B

12/31/2001

12/31/2001

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(5,057)	0	1,913	0	0	0	0	0	0	0	0	(3,144)
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0
32	Interest	(1,564)	0	49	0	0	0	0	0	0	0	0	(1,515)
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0
34	Rent-Facility & Grounds	0	0	3,670	0	0	0	0	0	0	0	0	3,670
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0
37	TOTAL Ownership	(6,621)	0	5,632	0	0	0	0	0	0	0	0	(989)
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0
39	Ancillary Service Centers	0	(58,043)	0	37,941	0	0	0	0	0	0	0	(20,102)
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0
44	TOTAL Special Cost Centers	0	(58,043)	0	37,941	0	0	0	0	0	0	0	(20,102)
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(15,139)	(168,163)	144,947	44,859	0	0	0	0	0	0	0	6,504

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CERTIFIED HEALTH MANAGEMENT	SKOKIE	BOOKKEEPING/ MANAGEMENT
				CHM THERAPY	SKOKIE	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEES	\$ 23,000	CERTIFIED HEALTH MANAGEMENT		\$	(23,000)	1
2	V	21 BOOKKEEPING FEES	87,120	CERTIFIED HEALTH MANAGEMENT			(87,120)	2
3	V							3
4	V							4
5	V	39 THERAPY	58,043	CHM THERAPY			(58,043)	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 168,163			\$	\$ * (168,163)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARE CENTRE OF URBANA

0041897

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 HOUSEKEEPING	\$			\$ 267	\$ 267 15
16	V	5 ELECTRICITY & GAS				430	430 16
17	V	6 MAINTENANCE				441	441 17
18	V	10 NURSING/MEDICAL RECORDS				11,428	11,428 18
19	V	17 ADMIN SALARIES				29,869	29,869 19
20	V	19 PROFESSIONAL FEES				6,259	6,259 20
21	V	20 FEES, SUBSCRIPTIONS				275	275 21
22	V	21 OFFICE EXPENSE				64,121	64,121 22
23	V	22 EMPLOYEE BENEFITS				12,597	12,597 23
24	V	24 TRAVEL/SEMINAR				5,257	5,257 24
25	V	25 TRANSPORTATION				5,391	5,391 25
26	V	26 INSURANCE				2,980	2,980 26
27	V	30 DEPRECIATION				1,913	1,913 27
28	V	32 INTEREST				49	49 28
29	V	34 OFFICE RENT				3,670	3,670 29
30	V	35 EQUIPMENT RENT				0	0 30
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 144,947	\$ * 144,947 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARE CENTRE OF URBANA# 0041897Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 THERAPY	\$			\$ 37,941	\$ 37,941 15
16	V	19 PROFESSIONAL FEE				160	160 16
17	V	21 OFFICE EXPENSE				1,320	1,320 17
18	V	22 EMPLOYEE BENEFITS				3,574	3,574 18
19	V	24 TRAVEL/SEMINARS				555	555 19
20	V	25 TRANSPORTATION				1,309	1,309 20
21	V	35 EQUIPMENT RENT					
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 44,859	\$ * 44,859 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRADLEY ALTER		ADMINISTRATIVE		SCHEDULE ATTACHED				\$ 18,275	17-3	1
2	HOWARD GELLER		ADMINISTRATIVE						4,725	19-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 23,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CARE CENTRE OF URBANA# 0041897Report Period Beginning: 01/01/2001Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CERTIFIED HEALTH MANAGEMENTStreet Address 3856 OAKTON SUITE 200City / State / Zip Code SKOKIE, IL 60076Phone Number (847) 674-4700Fax Number (847) 674-4733

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	279,537	8	\$ 3,000	\$ 24,847	\$ 267	1
2	5	ELECTRICITY & GAS	" " "	279,537	8	4,839	24,847	430	2
3	6	MAINTENANCE	" " "	279,537	8	4,965	24,847	441	3
4	10	NURSING/MEDICAL RECORDS	" " "	279,537	8	128,566	24,847	11,428	4
5	17	ADMIN SALARIES	" " "	279,537	8	336,038	24,847	29,869	5
6	19	PROFESSIONAL FEES	" " "	279,537	8	70,412	24,847	6,259	6
7	20	FEES, SUBSCRIPTIONS	" " "	279,537	8	3,089	24,847	275	7
8	21	OFFICE EXPENSE	" " "	279,537	8	721,384	24,847	64,121	8
9	22	EMPLOYEE BENEFITS	" " "	279,537	8	141,722	24,847	12,597	9
10	24	TRAVEL/SEMINAR	" " "	279,537	8	59,144	24,847	5,257	10
11	25	TRANSPORTATION	" " "	279,537	8	60,651	24,847	5,391	11
12	26	INSURANCE	" " "	279,537	8	33,528	24,847	2,980	12
13	30	DEPRECIATION	" " "	279,537	8	21,518	24,847	1,913	13
14	32	INTEREST	" " "	279,537	8	549	24,847	49	14
15	34	OFFICE RENT	" " "	279,537	8	41,293	24,847	3,670	15
16	35	EQUIPMENT RENT	" " "	279,537	8			0	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,630,698	\$ 1,037,584	\$ 144,947	25

Facility Name & ID Number CARE CENTRE OF URBANA# 0041897

Report Period Beginning:

01/01/2001Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CHM THERAPYStreet Address 3856 OAKTON SUITE 200City / State / Zip Code SKOKIE IL 60076Phone Number (847) 674-4700Fax Number (847) 674-4733

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39 THERAPY	USAGE	100	5	\$ 271,007	\$ 271,007	14	\$ 37,941	1
2	19 PROFESSIONAL FEE	USAGE	100	5	1,143		14	160	2
3	21 OFFICE EPXNESE	USAGE	100	5	9,430		14	1,320	3
4	22 EMPLOYEE BENEFITS	USAGE	100	5	25,530		14	3,574	4
5	24 TRAVEL/SEMINARS	USAGE	100	5	3,963		14	555	5
6	25 TRANSPORTATION	USAGE	100	5	9,348		14	1,309	6
7	35 EQUIPMENT RENT	USAGE	100	5					7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 320,421	\$ 271,007		\$ 44,859	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	SHAREHOLDER LOANS	X		WORKING CAPITAL				1,271,000		PRIME+	118,362	6	
7	BANK FINANCIAL		X	WORKING CAPITAL				327,849			25,765	7	
8	RELATED PARTY/OTHER	X									1,102	8	
9	TOTAL Facility Related						\$	\$ 1,598,849			\$ 145,229	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$ 1,598,849			\$ 145,229	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

- NOTES:**
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CARE CENTRE OF URBANA COUNTY CHAMPAIGN

FACILITY IDPH LICENSE NUMBER 0041897

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE (847) 674-4700 X40 FAX #: (847) 674-4733

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>91-21-07-282-021</u>	<u></u>	\$ <u>43,440.00</u>	\$ <u>43,440.00</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>43,440.00</u></u>	\$ <u><u>43,440.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000

B. General Construction Type: Exterior Frame

Number of Stories

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☒ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred: 5,664

2. Number of Years Over Which it is Being Amortized: 5 YEARS

3. Current Period Amortization: 579

4. Dates Incurred: 6/1/96

Nature of Costs: ORGANIZATION COSTS

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number CARE CENTRE OF URBANA

0041897

Report Period Beginning:

01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		TILES,WALLPAPER,PAINTING,HANDRAILS	1997		30,742	787	39	787		3,643	9
10		REPAIR PARKING LOT	1997		5,347	357	15	357		1,606	10
11		ROOF EXHAUSTER, VENTILATION	1997		4,926	126	39	126		548	11
12		CEILING,DUCTWORK,DOOR	1998		10,864	278	39	278		998	12
13		TILE/INSTALLATION	1998		4,650	119	39	119		412	13
14		HVAC UNIT	1998		6,162	158	39	158		543	14
15		NURSES STATION REPAIR	1998		12,552	312	39	312		1,400	15
16		300 WING RENOVATION	1998		7,859	202	39	202		665	16
17		FIRE PROTECTION SYSTEM/DAMPERS	1999		37,334	957	39	957		2,057	17
18		LANDSCAPING/SIDEWALK	1999		17,035	438	39	438		939	18
19		WALL REPAIR/TILE/HANDRAIS/BUMPERS	2000		8,740	248	27.5	248		474	19
20		BASEBOARD HEAT	2000		2,306	123	27.5	123		179	20
21		NEW WATER SERVICE/WATER HEATER	2000		10,597	415	27.5	415		689	21
22		FIRE ALARM WORK	2000		9,647	351	27.5	351		601	22
23		ROOF REPAIR	2001		11,820	269	27.5	269		269	23
24		ROOF REPAIR	2001		3,056	32	27.5	32		32	24
25		WALL REPAIR AND TILE	2001		2,301	10	27.5	10		10	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 185,938	\$ 5,182		\$ 5,182	\$	\$ 15,065	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 109,793	\$ 15,611	\$ 10,979	\$ (4,632)	10 YRS	\$ 38,612	71
72	Current Year Purchases	11,685	1,392	584	(808)	10 YRS	584	72
73	Fully Depreciated Assets							73
74		22,962	1,913	2,296	383			74
75	TOTALS	\$ 144,440	\$ 18,916	\$ 13,859	\$ (5,057)		\$ 39,196	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 330,378	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,098	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,041	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,057)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 54,261	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CARE CENTER OF URBANA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		99	6/1/96	\$ 372,389			3
4	Additions							4
5								5
6								6
7	TOTAL		99		\$ 372,389			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☒ YES ☐ NO Terms: PURCHASE AFTER 6/1/16 *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 2,915 Description: SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 6/1/96

Ending 5/31/21

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/2002 \$ 384,687

13. 12/31/2003 \$ 393,721

14. 12/31/2004 \$ 409,256

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	39-3	hrs	\$		
2	Licensed Speech and Language Development Therapist	39-3	hrs				150			150	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				20,300			20,300	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$ 58,043	\$		\$ 58,043		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 36,000)	495,706		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,247		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	36,490		8
9	Other(specify): R/E ESCROW	36,024		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 638,467	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	185,938		15
16	Equipment, at Historical Cost	121,478		16
17	Accumulated Depreciation (book methods)	(90,238)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	297,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 514,178	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,152,645	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 535,908	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,000		28
29	Short-Term Notes Payable	327,849		29
30	Accrued Salaries Payable	46,008		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,832		31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,309		32
33	Accrued Interest Payable	191,685		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,155,591	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,271,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,271,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,426,591	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,273,946)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,152,645	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,244,231)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,244,231)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(29,715)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (29,715)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,273,946)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,689,718	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,689,718	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	13,202	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 13,202	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	4,468	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,468	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,707,388	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	495,947	31
32	Health Care	963,814	32
33	General Administration	577,787	33
B. Capital Expense			
34	Ownership	587,309	34
C. Ancillary Expense			
35	Special Cost Centers	58,043	35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,737,103	40
41	Income before Income Taxes (line 30 minus line 40)**	(29,715)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (29,715)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **CARE CENTRE OF URBANA**

0041897

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,920	2,060	\$ 44,156	\$ 21.43	1
2	Assistant Director of Nursing	1,952	2,080	32,763	15.75	2
3	Registered Nurses	4,350	4,664	87,182	18.69	3
4	Licensed Practical Nurses	8,310	8,602	136,771	15.90	4
5	Nurse Aides & Orderlies	31,140	31,539	342,948	10.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,111	2,286	27,460	12.01	8
9	Activity Director	1,772	1,803	18,676	10.36	9
10	Activity Assistants	2,037	2,112	14,860	7.04	10
11	Social Service Workers	2,477	2,565	32,592	12.71	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	35,868	17.24	13
14	Head Cook	8,241	8,672	64,273	7.41	14
15	Cook Helpers/Assistants	4,831	4,869	31,513	6.47	15
16	Dishwashers					16
17	Maintenance Workers	1,000	1,040	13,946	13.41	17
18	Housekeepers	8,472	8,574	85,574	9.98	18
19	Laundry	4,869	4,945	30,438	6.16	19
20	Administrator	1,635	1,680	45,496	27.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,992	2,192	29,659	13.53	23
24	Clerical	3,190	3,375	27,746	8.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,584	1,698	15,576	9.17	31
32	Other Health C: Care Plan Coord.	2,502	2,562	27,831	10.86	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,385	99,398	\$ 1,145,328 *	\$ 11.52	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 4,695	1-3	35
36	Medical Director		9,000	9-3	36
37	Medical Records Consultant		12,425	10-3	37
38	Nurse Consultant		4,500	10-3	38
39	Pharmacist Consultant		825	10-3	39
40	Physical Therapy Consultant		1,213	10a-3	40
41	Occupational Therapy Consultant		875	10a-3	41
42	Respiratory Therapy Consultant		2,169	10a-3	42
43	Speech Therapy Consultant		288	10a-3	43
44	Activity Consultant		2,164	11-3	44
45	Social Service Consultant		1,944	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 40,098		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	27	\$ 730	L10C3	50
51	Licensed Practical Nurses		0	L10C3	51
52	Nurse Aides	3,307	72,991	L10C3	52
53	TOTAL (lines 50 - 52)	3,334	\$ 73,721		53

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
JOAN DARR	ADMINISTRATOR		\$ 13,644	Workers' Compensation Insurance	\$ 32,024		IDPH License Fee	\$ 3,408
EILEEN KARTER	ADMINISTRATOR		24,587	Unemployment Compensation Insurance	26,075		Advertising: Employee Recruitment	3,408
MARK BERG	ADMINISTRATOR		7,265	FICA Taxes	87,538		Health Care Worker Background Check (Indicate # of checks performed _____)	
				Employee Health Insurance	42,454		ADVERTISING	4,056
				Employee Meals			LICENSE/FEES	1,885
				Illinois Municipal Retirement Fund (IMRF)*			DUES, BOOKS, SUBSC	6,276
				OTHER	(57)		ADV YELLOW PAGES	647
				RELATED PARTY	16,171			
							RELATED PARTY	275
							Less: Public Relations Expense ()
							Non-allowable advertising	(4,056)
							Yellow page advertising	(647)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 45,496				TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,844
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)	\$ 204,205	G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
MANAGEMENT FEES			\$ 23,000				Out-of-State Travel	\$
							In-State Travel	
								1,452
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 23,000				Seminar Expense	
C. Professional Services								1,225
Vendor/Payee	Type		Amount				RELATED PARTY	5,812
WINSTON & STRAWN	LEGAL		\$ 3,272				Entertainment Expense ()
OTHER LEGAL	LEGAL		147				(agree to Sch. V, line 24, col. 8)	
KRUPNICK, BOKOR,KAGDA	ACCTG		7,350				TOTAL	\$ 8,489
RICHARD PEELO & ASSOC	ACCTG		4,250					
ECONOCARE	ADMIN CONSULT		1,634					
NORMAN JAMES DDS	CONSULT		50					
CARLE MEDICAL	PROF SVCS		218					
PERSONNEL PLANNERS	HR CONSULT		1,834					
CERTIFIED HEALTH	ADMIN CONSULT		27,835					
MILLENIUM	DATA PROCESSING		4,993					
RELATED PARTY			6,419					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 58,002	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINTING/DECORATING	1997	\$ 8,079	3	\$ 2,693	\$ 2,693	\$ 1,346	\$	\$	\$	\$	\$	\$
2	PAINTING/DECORATING	1998	5,197	3	866	1,732	1,732	867					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 13,276		\$ 3,559	\$ 4,425	\$ 3,078	\$ 867	\$	\$	\$	\$	\$

Facility Name & ID Number CARE CENTRE OF URBANA

STATE OF ILLINOIS

0041897

Report Period Beginning: 01/01/2001

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILL HEALTH CARE ASSOC \$5,784
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 188 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54,203
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: CARE CENTRE OF URBANA

#0041897

Report Period Beginning: 01/01/2001

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V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	4,695
	REPAIRS & MAINTENANCE	550
		5,245
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	11,848
	ELECTRICITY	42,856
	WATER	14,050
	CABLE TV - LOBBY	470
		0
		69,224
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,702
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	1,169
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,085
	FIRE SERVICE	2,124
		0
		7,080
7	OTHER	
	SCAVENGER	3,881
	SECURITY SERVICE	0
		3,881
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,000
		9,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	73,721
	LABORATORY & XRAY EXPENSE	2,692
	PURCHASED SERVICES	560
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	12,425
	PHARMACY CONSULTANT XVIII B 39-2	825
	UTILIZATION REVIEW FEES XVIII B -2	0
		0
	NURSE PROGRAM CONSULT.	4,500
	RN CONSULTANT XVIII B 38-2	
		0
		94,723
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	1,213
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	875
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	2,169
	SPEECH THERAPY CONSULTANT XVIII B 43-2	288
		4,545
11	ACTIVITIES	
	CABLE TV - PATIENT ROOM	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
	ACTIVITY PROGRAM EXP	2,164
		2,164
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,944
		0
		1,944
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

Facility Name & ID#: CARE CENTRE OF URBANA

#0041897 Report Period Beginning: 01/01/2001

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V.COST CENTER EXPENSES		PAGE 3 COLUMN 3 OTHER	
LINE	SCHED REF		TOTAL
14		PROGRAM TRANSPORTATION	
		PATIENT TRANSPORTATION	0
17		ADMINISTRATIVE	
	XIX B	MANAGEMENT FEES	23,000
18		DIRECTORS FEES	0
19		PROFESSIONAL SERVICES	
	XIX C	DATA PROCESSING	4,993
	XIX C	ADMINISTRATIVE CONSULTANTS	27,835
	XIX C	PROFESSIONAL FEES	18,755
			0
20		FEES,SUBSCRIPTIONS,PROMOTIONS	51,583
	VI 19 XIX F	ENTERTAINMENT & MARKETING	
	VI 25 XIX F	ADV & PROMO-NON PATIENT RELATED	4,056
	XIX F	EMPLOYEE WANT ADS	3,408
	VI 20 XIX F	CONTRIBUTIONS	0
	XIX F	DUES & SUBSCRIPTIONS	6,276
	XIX F	LICENSES & PERMITS	1,885
	XIX F	PUBLIC RELATIONS-PATIENT RELATED	0
	VI 28 XIX F	ADVERTISING-YELLOW PAGES	647
	VI 17 XIX F	TRUST FEES / FRANCHISE TAX / ETC	0
	VI 20 XIX F	CONTRIBUTIONS - POLITICAL	0
	XIX F	HEALTH CARE WORKER BACKGROUND CHEC	0
21		CLERICAL & GENERAL OFFICE EXPENSES	16,272
		BANK CHARGES	3,551
		EQUIPMENT REPAIR & MAINTENANCE	1,889
		OUTSIDE CLERICAL SERVICES	87,120
	VI 18	PENALTIES / OVERDRAFT CHARGES	7,470
		HOME OFFICE EXPENSES	0
		THEFT & DAMAGE LOSS	289
		TELEPHONE	10,562
		POSTAGE	2,774
		STORAGE RENTAL	920
			114,575

LINE	SCHED REF		TOTAL
22		EMPLOYEE BENEFITS & PAYROLL TAXES	
	XIX D	FICA TAXES	87,538
	XIX D	UNEMPLOYMENT COMPENSATION	26,075
	XIX D	WORKERS COMPENSATION INSURANC	32,024
	XIX D	HOSPITALIZATION INSURANCE	42,454
	XIX D	EMPLOYEE BENEFITS - OTHER	(57)
	XIX D	EMPLOYEE PHYSICAL EXAMS	0
	VI 21/XIX D	INSURANCE - EXECUTIVE LIFE	0
	XIX D	PENSION/PROFIT SHARING PLANS	0
	XIX D	OTHER	0
			188,034
23		INSERVICE TRAINING & EDUCATION	
		EDUCATION & SEMINARS	0
24		TRAVEL & SEMINARS	
	XIX G	EDUCATION & SEMINARS	1,300
	XIX G	TRAVEL	1,377
			0
			0
			2,677
25		ADMIN. STAFF TRANSPORTATION	
		TRANSPORTATION - STAFF	1,913
26		INSURANCE - PROP. LIAB & MALPRACTICE	
		GENERAL INSURANCE	46,449
27		OTHER	
	VI 24	BAD DEBTS	0
			0

GRAND TOTAL COLUMN 3 OTHER

642,309